

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County Stone  
Township Rich  
City (No. ....) (St. ....) (Ward) .....

Registration District No. 845  
Primary Registration District No. 6108

File No. 27985  
Registered No. ....

**2. FULL NAME**

Malinda Jane Ellis  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.  
(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jerry Ellis  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16 1851  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
82 9 23

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Ill

10. NAME OF FATHER J W McCord

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Martha Herrick

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't know

**14.**

INFORMANT Mrs. Bessie Sharp

(Address) Reeds Spring Mo.

**15.**

FILED 7/9/1934

L. S. Shemate

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1934

17. I HEREBY CERTIFY, That I attended deceased from June 1 1934 to July 9 1934  
that I last saw her alive on July 8 1934, and that death occurred, on the date stated above, at 10:30 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Quadrant adenocarcinoma

46 B

117 B

121 B

**CONTRIBUTORY (SECONDARY)**

Catarrh of Gall Bladder (duration) 2 yrs. mos. ds.  
+ papillary (duration) 5 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) L. S. Shemate

M. D.

7/9/1934 (Address) Reeds Spring Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Bradfield Mo

**DATE OF BURIAL**

9/10/1934

**20. UNDERTAKER**

Mrs. Hattie Stults Reeds Spring Mo

**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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